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GIVING AN INCH, THEN TAKING A MILE: HOW THE GOVERNMENT'S UNRESTRICTED RECOVERY OF CONDITIONAL MEDICARE PAYMENTS DESTROYS PLAINTIFFS' CHANCES AT COMPENSATION THROUGH THE TORT SYSTEM

NICOLE MIKLOS[†]

INTRODUCTION

On a snowy February morning, Susan Smith, a retired nursery school teacher, aged seventy, who had generally been in good health her whole life, slipped and fell on the steps to her apartment. Ms. Smith's fractured ankle required surgery to heal properly. Although she had a modest retirement cushion, Ms. Smith could not cover the costs of surgery and rehabilitation. Luckily, Ms. Smith had some assistance from Medicare, enabling her to pay for the metal rods and bolts the doctors installed in her bones to allow for proper healing. Unluckily, Ms. Smith suffered a severe infection following the surgery, resulting from poor aftercare. Unable to return home, Ms. Smith endured an extended, painful recovery in a nursing home. Weighed down by the unanticipated medical expenses, Ms. Smith contacted an attorney to learn what compensation she might recover if she sued the hospital. The attorney informed Ms. Smith that while she could recover a substantial sum, the amount recovered would likely be significantly reduced in light of the fact that the government would be entitled to recover from such a lawsuit any amount that Medicare had paid for Ms. Smith's treatment. Ms. Smith decided to sue, and her attorney notified Centers for Medicare & Medicaid Services ("CMS") that the suit would be brought.

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Ms. Smith sued the hospital alleging negligence and medical malpractice, hoping to receive compensation for her past and future expenses and troubles. Ms. Smith alleged damages of \$110,000 in medical expenses (of which Medicare paid \$50,000); \$10,000 in lost wages and future earning potential; and \$80,000 in pain and suffering. The claim for damages totaled \$200,000. The case quickly settled for \$50,000.¹ After the settlement funds were dispersed, the Secretary of Health and Human Services filed suit against Ms. Smith and her attorney under the Medicare Secondary Payer Act ("MSP"), seeking reimbursement for the \$50,000 Medicare had paid on Ms. Smith's behalf.²

If the government is entitled to recover its entire claim, Ms. Smith will be left uncompensated for her injuries and more dependent than ever on public assistance. When a Medicare beneficiary settles, one can infer that the beneficiary has been compensated for a portion of each damage claim. Thus, Ms. Smith recovered only twenty-five percent of the total value of her damages, suggesting she was not fully compensated for any one of her damage claims, but rather compensated for a portion of each. As a general matter, the government is justified in recouping payments it made through Medicare because this money was paid out by the government, not by Ms. Smith. If the government recoups its entire \$50,000 payout, however, it will actually be recovering the portion of money designed to compensate Ms. Smith for non-Medicare related costs, such as her out of pocket medical expenses, pain and suffering, and future care costs. Because the MSP does not directly address the issue of apportioned recovery,³ the statute should be read to limit the government's recovery to only those settlement funds intended to compensate her for past medical expenses paid for by Medicare.

This Note argues that the government's recovery of conditional Medicare payments should be limited to those settlement proceeds designated for past medical expenses, calling for a reconciliation of the government's financial interests and

¹ See *Zinman v. Shalala*, 67 F.3d 841, 843 (9th Cir. 1995) (discussing a hypothetical scenario).

² See Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries*, 41 AKRON L. REV. 557, 558 (2008).

³ See *Zinman*, 67 F.3d at 845 (citing *United States v. Travelers Ins. Co.*, 815 F. Supp. 521, 523 (D. Conn. 1992)).

the plaintiff's compensatory interests in the tort system. Part I of this Note discusses the evolution of Medicare's and Medicaid's role as public medical insurance programs. This Part also examines the confusion regarding the extent of the government's reimbursement rights. Part II addresses the Supreme Court's recent decision in *Arkansas Department of Health & Human Services v. Ahlborn*,⁴ which held that Medicaid reimbursements are limited to those settlement funds intended to compensate the plaintiff for past medical expenses. Part III argues that this limited recovery rule should extend to Medicare reimbursements in light of similar language in the Medicaid and Medicare statutes, as well as the common need to balance the government's statutory rights with the tort system's compensation goals. Part IV provides a suggestion as to how courts should implement the limited recovery rule.

I. DISCUSSION

A. *The History of Medicaid and Medicare: The Government's Evolving Role as a Healthcare Insurer*

Medicare and Medicaid are the two major government-sponsored health care programs, which together provide health care insurance to approximately one in four Americans.⁵ The programs are both administered on the federal level by CMS, an agency under the United States Department of Health & Human Services ("HHS").⁶ CMS, originally called the Health Care Financing Administration,⁷ was created to combine under one roof "the oversight of the Medicare program [and] the Federal portion of the Medicaid program."⁸ Although the programs are

⁴ 547 U.S. 268 (2006).

⁵ See U.S. Department of Health & Human Services, HHS: What We Do, <http://www.hhs.gov/about/whatwedo.html> (last visited Mar. 21, 2010) [hereinafter HHS: What We Do].

⁶ See *id.*

⁷ See U.S. Department of Health & Human Services, Letter from William L. Engelhardt, <http://www.cms.hhs.gov/CMSAlumni> (last visited Mar. 21, 2010).

⁸ U.S. Department of Health & Human Services, Health Care Financing Administration, <http://www.hhs.gov/about/opdivs/hcfa.html> (last visited Mar. 21, 2010).

structured differently, they have the same goal: protecting the health of Americans, "especially . . . those who are least able to help themselves."⁹

Unfortunately, the government's desire to maximize its recovery has jeopardized these goals. Implementation of the programs has evolved over the years in ways that have hurt those the programs were intended to help, while simultaneously threatening the function of the tort system as a means of compensation.

1. Program Basics

Medicaid was enacted in 1965 as a publicly funded program to ensure that certain individuals who lack the resources to cover the cost of essential medical services would have access to health care.¹⁰ Under Medicaid, the federal government and the individual state governments share the cost of paying for the health care services of low-income citizens.¹¹ Each state establishes and implements its own Medicaid program in compliance with certain federal requirements, including who should be eligible for aid and how to administer the program. In return, the federal government pays for the majority of costs that each state incurs.¹²

Medicare, also enacted in 1965,¹³ supports a smaller group of people. Medicare provides the funding of medical care for those over the age of sixty-five, those who are younger than sixty-five and have been recipients of Social Security disability benefits for at least twenty-four months, those suffering from end-stage renal disease, and the permanently disabled.¹⁴

2. The Government's Reimbursement Right

From its inception, Congress intended Medicaid to be "the payer of last resort."¹⁵ To participate in Medicaid, states are required to seek reimbursement of benefits paid whenever there is a liable third party—such as the beneficiary's own insurer—as

⁹ HHS: What We Do, *supra* note 5.

¹⁰ See *Norwest Bank of N.D. v. Doth*, 159 F.3d 328, 331 (8th Cir. 1998); 42 C.F.R. § 430.0 (2010).

¹¹ See 42 C.F.R. § 430.0.

¹² See 42 U.S.C. § 1396d(b) (2006).

¹³ See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286.

¹⁴ See 42 U.S.C. § 1395c.

¹⁵ S. REP. NO. 99-146, at 311 (1985), *reprinted in* 1986 U.S.C.C.A.N. 264, 278.

well as tortfeasors and their liability insurers. To effectuate this federal mandate, each state must enact laws to enable recovery for payments made for medical services on behalf of Medicaid beneficiaries.¹⁶

Unlike Medicaid, Medicare was intended to be the primary payer of medical services for Medicare beneficiaries from the time it was signed into law.¹⁷ As originally enacted, the program would pay for “medical services supplied to a beneficiary, even when such services were covered by other insurance such as an employer group health plan or liability insurance.”¹⁸

The growing costs of the program, however, prompted Congress to amend the program, shifting Medicare from the primary payer of medical care to the payer of last resort.¹⁹ Congress passed an amendment to section 1862(b) of the Social Security Act, now known as the MSP.²⁰ The MSP, “for the first time since Medicare’s inception . . . made Medicare’s liability secondary to additional sources of payment for Medicare beneficiaries’ medical costs and services.”²¹ Medicare will not pay for any service or item in which “payment has been made or can reasonably be expected to be made” by a primary plan, such as workers’ compensation, self-insured plans, or liability insurance.²² Medicare will, however, make payments when a Medicare recipient cannot expect to receive prompt payment from such third-party payers,²³ on the condition that such payments are reimbursed to Medicare when payment for such

¹⁶ See 42 U.S.C.A. §§ 1396a(a)(18), 1396p(a)–(b) (West 2010). These recovery mandates are not, however, without limitation. Federal law specifically prohibits states from recovering payments from the property of the Medicaid beneficiary. See *id.* §§ 1396a(a)(18), 1396p(a).

¹⁷ See *Zinman v. Shalala*, 67 F.3d 841, 843 (9th Cir. 1995); see also *Health Ins. Ass’n of Am. v. Shalala*, 23 F.3d 412, 414 (D.C. Cir. 1994).

¹⁸ *Zinman*, 67 F.3d at 843.

¹⁹ See *id.* (explaining that the MSP legislation was enacted in response to “skyrocketing Medicare costs”); *In re Zyprexa Prods. Liab. Litig.*, 451 F. Supp. 2d 458, 465 (E.D.N.Y. 2006) (“The [MSP] . . . sought to lower Medicare’s expenses . . .”). See generally Swedloff, *supra* note 2, at 572 (“Medicare expenses rapidly expanded beyond Congress’ initial expectation, and Congress scrambled to reign in the program’s spending.”).

²⁰ See Swedloff, *supra* note 2, at 574.

²¹ *Id.*

²² 42 U.S.C.A. § 1395y(b)(2)(B)(ii) (West 2010).

²³ See *id.* § 1395y(b)(2)(B)(i).

services are received.²⁴ As a result, Congress successfully cut the costs of the program by "requiring that Medicare pay 'secondary' to alternate sources,"²⁵ ultimately "shifting the costs of beneficiaries' medical care from the Medicare program to private sources of payment."²⁶

Despite the clearly stated purpose of the MSP, the government had limited success recovering under the statute's complex language as originally drafted.²⁷ The government's string of unsuccessful recovery efforts can be attributed to the significant differences in interpretation of the MSP among the courts.²⁸ The government turned its attention to the high-profile mass tort settlements in the late 1990s and sought to recover Medicare's expenditures from the alleged tortfeasors who settled with Medicare beneficiaries.²⁹

The government found a novel theory to justify reimbursement from tort settlements because recovery under such circumstances was not clearly authorized by the MSP. The government argued that it could recover from settlement funds because the MSP authorized recovery against "primary plans,"

²⁴ See *id.* § 1395y(b)(2)(B) (explaining that any payment under this subchapter with respect to an item or service shall be conditioned on reimbursement when notice or other information of the primary's plan responsibility is received by such primary plan).

²⁵ *Blue Cross & Blue Shield Ass'n v. Sullivan*, 794 F. Supp. 1166, 1169 (D.D.C. 1992); see also *United States v. Baxter Int'l, Inc.*, 174 F. Supp. 2d 1242, 1250 (N.D. Ala. 2001) (discussing the purpose and structure of the MSP), *rev'd*, 345 F.3d 866, 875 (11th Cir. 2003).

²⁶ Swedloff, *supra* note 2, at 575.

²⁷ See *Baxter*, 345 F.3d 866, 875 (11th Cir. 2003) ("[T]he statute is structurally complex—a complexity that has produced considerable confusion among [the] courts attempting to construe it."); see also *Estate of Urso v. Thompson*, 309 F. Supp. 2d 253, 259 (D. Conn. 2004) (noting that the Medicare statute is "convoluted and complex and such a model of *un-clarity*"); *Brown v. Thompson*, 252 F. Supp. 2d 312, 317 n.5 (E.D. Va. 2003) ("There is no doubt that the MSPS is not a model of clarity and coherence."), *aff'd*, 374 F.3d 253 (4th Cir. 2004).

²⁸ See Norma S. Schmidt, *The King Kong Contingent: Should the Medicare Secondary Payer Statute Reach to Future Medical Expenses in Personal Injury Settlements?*, 68 U. PITT. L. REV. 469, 472–73 (2006) (discussing CMS's "mixed success in its early attempts to recover Medicare liens" due to varied statutory interpretations of the MSP); see also *In re Zyprexa Prods. Liab. Litig.*, 451 F. Supp. 2d 458, 465 (E.D.N.Y. 2006) ("For many years courts were divided about the propriety of the federal government's attempts to recover Medicare expenditures under the MSP in cases involving settled tort claims.").

²⁹ See Swedloff, *supra* note 2, at 579.

which included a “self-insured plan.”³⁰ Since the statute did not define “self-insured plan,” the government argued that the alleged tortfeasors were “self-insured” because they chose to carry their own risk in lieu of purchasing an insurance policy, ultimately paying their own money out to the Medicare beneficiaries who were plaintiffs in the suit.³¹

Ultimately, the government’s position was rejected because it represented a significant departure from prior understandings of the MSP.³² District courts throughout the country concluded that the plain language of the statute precluded the government from recovering from an individual beneficiary’s settlement of claims.³³ The Fifth Circuit in *Thompson v. Goetzman*,³⁴ the first appellate level court to rule on the matter, “agree[d] with the . . . district courts that have concluded that an alleged tortfeasor who settles with a plaintiff is not, *ipso facto*, a ‘self-insurer’ under the MSP statute.”³⁵ Therefore, an uninsured defendant without a formal self-insurance plan did not constitute a “primary plan” from which Medicare was authorized under the MSP to recover conditional payments from. Such courts reasoned that “the Government’s MSP cause of action arises when the ‘primary plan’ is obligated to pay for the primary care at issue under a contract of insurance, not when the payment obligation arises out of tort litigation.”³⁶ The *Thompson* Court focused primarily on the statutory text, explaining that, if “the plain language of the MSP statute produces the legislatively

³⁰ See 42 U.S.C. § 1395y(b)(2)(A)(ii) (2006); *Thompson v. Goetzmann*, 337 F.3d 489, 495 (5th Cir. 2003).

³¹ See *Thompson*, 337 F.3d at 495.

³² See *Health Ins. Ass’n of Am. v. Shalala*, 23 F.3d 412, 427 n.* (D.C. Cir. 1994) (Henderson, J., concurring) (concluding that the statute was intended “to allow recovery only from an insurer”); *United States v. Philip Morris Inc.*, 116 F. Supp. 2d 131, 146 n.22 (D.D.C. 2000) (“Courts have uniformly recognized that the statute’s clear purpose was to grant the Government a right to recover Medicare costs from [insurers].”).

³³ See *Thompson*, 337 F.3d at 494 (“[T]he government has litigated similar cases in several district courts around the country . . . [and] the government’s prior efforts have proved uniformly feckless—every court that has heard its arguments on this issue . . . has rejected the government’s expansive interpretation of the MSP statute.”).

³⁴ *Id.*

³⁵ *Id.* at 497.

³⁶ *In re Diet Drugs Prods. Liab. Litig.*, 2001 WL 283163, at *11 (E.D. Pa. Mar. 21, 2001); see also *Thompson*, 337 F.3d at 498.

unintended result claimed by the government, the government's complaint should be addressed to Congress, not to the courts, for such revision as Congress may deem warranted, if any."³⁷

Congress amended the MSP in 2003 to reflect growing concerns about the statute's intended application,³⁸ simultaneously ensuring that tortfeasors would be a new source of reimbursement.³⁹ Congress defined "self-insured plan" to include an entity that "carries its own risk . . . in whole or in part."⁴⁰ This change brought settling tortfeasors under the umbrella of self-insuring entities from whom the government could recover.⁴¹ After the 2003 amendments, the MSP "plainly entitles Medicare to reimbursement of any payment it makes for medical services if a primary plan later pays for those medical services as part of a settlement agreement."⁴²

B. Remaining Issues: The Scope of the MSP and What It Means for Medicare Beneficiaries Attempting To Settle Tort Suits

The government has seen successful recovery efforts since the amendments,⁴³ but questions remain regarding the full scope of the government's recovery rights under the MSP. There is no disagreement that the government is entitled to recoup Medicare expenditures when a judgment, arbitration agreement, or settlement specifically includes consideration for past medical expenses.⁴⁴ The statute does not clearly state recovery rights in other situations, however, such as when personal injury settlements specifically exclude past medical expenses, or a release provides that Medicare retains its right to bring an

³⁷ *Thompson*, 337 F.3d at 493.

³⁸ The amendment was made by enacting the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301, 117 Stat. 2066, 2221.

³⁹ See Swedloff, *supra* note 2, at 582 ("Congress moved swiftly to amend the MSP to reflect the government's failed litigation positions.").

⁴⁰ 42 U.S.C.A. § 1395y(b)(2)(A) (West 2010).

⁴¹ See *infra* note 94 and accompanying text.

⁴² See *Brown v. Thompson*, 374 F.3d 253, 258 (4th Cir. 2004).

⁴³ Thereafter, more courts held that the MSP entitled the government to its fair share of the individual Medicare beneficiary's tort settlement. See, e.g., *Estate of Urso v. Thompson*, 309 F. Supp. 2d 253, 256-59 (D. Conn. 2004); *Brown v. Thompson*, 252 F. Supp. 2d 312, 319 (E.D. Va. 2003), *aff'd*, 374 F.3d 253.

⁴⁴ See J. Michael Hayes, *Are Medicare, Medicaid, and ERISA Liens?*, 79 N.Y. ST. B.J. 28, 29 (2007).

independent action.⁴⁵ Settlements have been particularly problematic because the MSP “does not address the issue of apportioned recovery of conditional Medicare payments, either by its language or by its structure.”⁴⁶

If Medicare pays for services that later become the subject of a medical malpractice suit that settles, should the government be entitled to recover its full expenditures from the Medicare beneficiary’s settlement proceeds? If the Medicare expenditure total is so high that full reimbursement would essentially wipe out the plaintiff’s recovery, would it instead be more just to apportion the settlement proceeds and limit the government’s recoupment to only that portion of the settlement allocated for past medical expenses? If Medicare’s recovery should be limited in that manner, how should courts determine the amount paid in the absence of an express allocation for past medical expenses?⁴⁷ Left unresolved, the government will surely seek to maximize its recovery, hurting individual Medicare beneficiaries, but more importantly, threatening the tort system’s compensation goals by destroying the incentive to sue.⁴⁸

II. LIMITATIONS ON STATE MEDICAID RECOVERY UNDER *AHLBORN*

In 2006, the Supreme Court, in *Arkansas Department of Health & Human Services v. Ahlborn*,⁴⁹ resolved these issues with regard to Medicaid, stating that the federal Medicaid statute limits the government’s recovery to compensation for past medical expenses.⁵⁰ Prior to *Ahlborn*, there was a split among courts. Some held that the state was entitled to recover on its Medicaid lien from any liability claim asserted against a third party by the Medicaid beneficiary, regardless of the damage

⁴⁵ See *id.* at 29–30.

⁴⁶ See *Zinman v. Shalala*, 67 F.3d 841, 845 (9th Cir. 1995).

⁴⁷ See *Lugo v. Beth Israel Med. Ctr.*, 13 Misc. 3d 681, 682–83, 819 N.Y.S.2d 892, 893 (Sup. Ct. Nassau County 2006) (enumerating similar issues relating to the New York Medicaid agency’s right of recovery in a medical malpractice suit).

⁴⁸ See Irma S. Russell, *The Logic of Legal Remedies and the Relative Weight of Norms: Assessing the Public Interest in the Tort Reform Debate*, 39 AKRON L. REV. 1053, 1064–65 (2006) (discussing the compensatory goals of tort law).

⁴⁹ 547 U.S. 268 (2006).

⁵⁰ See *id.* at 280.

calculation.⁵¹ In those courts, the government could claim reimbursement from the pool of money intended to compensate the victim not only for medical expenses, but also for pain, suffering, and lost wages. Other courts took the position that the state's right of recovery was limited to the portion of money intended to compensate for past medical expenses.⁵²

Heidi Ahlborn, a nineteen year-old college student, became Medicaid eligible after a car accident left her severely brain-damaged.⁵³ Arkansas Department of Health and Human Services ("ADHS"), the state Medicaid agency, paid \$215,645.30 for medical services to health care providers on Ahlborn's behalf.⁵⁴ Ahlborn initiated a tort lawsuit in state court, which settled for \$550,000, with no allocation between medical and nonmedical expenses.⁵⁵ Medicaid asserted a right to full reimbursement for the \$215,645.30 it paid out.⁵⁶ Although the parties eventually stipulated that the settlement of \$550,000 represented one-sixth the value of her tort claim,⁵⁷ the question remained whether Medicaid repayment would be deducted from Ahlborn's entire claim or, instead, deducted only from a portion of the claim attributable to past medical expenses.

The Supreme Court sided with Ahlborn, rejecting the state agency's claim entitling it to more than the portion of Ahlborn's settlement representing medical expenses.⁵⁸ The Supreme Court explained that while the Arkansas statute required recoupment from,⁵⁹ and placed a lien on,⁶⁰ the entire third-party payment, the federal Medicaid statute "does not sanction an assignment of rights to payment for anything other than medical expenses—not

⁵¹ See, e.g., *Houghton v. Dep't of Health*, 57 P.3d 1067, 1069 (Utah 2002); *Wilson v. State*, 10 P.3d 1061, 1066 (Wash. 2000); *Calvanese v. Calvanese*, 93 N.Y.2d 111, 116, 710 N.E.2d 1079, 688 N.Y.S.2d 479 (1999).

⁵² See, e.g., *Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1, 13 (Minn. 2002).

⁵³ *Ahlborn*, 547 U.S. at 272–73.

⁵⁴ *Id.* at 273.

⁵⁵ *Id.* at 274.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at 291–92.

⁵⁹ ARK. CODE ANN. § 20-77-302(a) (2009) (stating that when a Medicaid recipient brings a claim against a liable third party, "any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program").

⁶⁰ See *supra* text accompanying note 42.

lost wages, not pain and suffering, not an inheritance.”⁶¹ Additionally, “the federal statute places express limits on the State’s powers to pursue recovery” by requiring compliance with the federal anti-lien provision,⁶² which “generally prevents a State from attaching property of a recipient to reimburse the State for benefits paid under a state Medicaid plan.”⁶³ Under the Arkansas law, Medicaid beneficiaries must automatically assign to the ADHS their full rights to recoveries,⁶⁴ creating an automatic lien on any funds the Medicaid recipient received from a third party.⁶⁵ The Court acknowledged that while Congress clearly intended Medicaid to be the payer of last resort, that did not mean Congress intended the government to be able to “seek reimbursement from Medicaid recipients themselves; in fact, with the possible exception of a lien on payments for medical care, the statute expressly prohibits liens against the property of Medicaid beneficiaries.”⁶⁶

III. ANALYSIS

It is unclear whether *Ahlborn* will also govern Medicare reimbursement rights because *Ahlborn* is specific to Arkansas’s Medicaid program and does not automatically extend to the implementation of the federal Medicare program. Additionally, Medicaid and Medicare are governed by different statutes. Certain portions of the ruling, such as the rejection of Arkansas’s automatic assignment provision, are wholly inapplicable because there is no comparable federal anti-lien provision in the MSP.

The government’s recovery rights are considered more extensive for Medicare payments than for Medicaid payments, further clouding whether a limited right of recovery under Medicaid also applies to Medicare. Medicare’s conditional payments create a lien, “tak[ing] precedence over any other claim against settlement proceeds, including those of Medicaid, and trumps even the injured party’s right to reimbursement.”⁶⁷ Some commentators describe the government’s right of recovery under

⁶¹ *Ahlborn*, 547 U.S. at 281.

⁶² *Id.* at 283.

⁶³ *Ahlborn v. Ark. Dep’t of Human Servs.*, 397 F.3d 620, 623 (8th Cir. 2005), *aff’d*, 547 U.S. 268.

⁶⁴ See ARK. CODE ANN. § 20-77-307(a).

⁶⁵ See *id.* § 20-77-307(c).

⁶⁶ *Ahlborn*, 547 U.S. at 291–92.

⁶⁷ Schmidt, *supra* note 28, at 474.

the Medicare statutes as a "super lien."⁶⁸ Others suggest that the government's right of recovery under the Medicare statutes has been exaggerated.⁶⁹

The government's reimbursement rights under Medicare are strong, but the MSP's language and principles are not so different from the federal Medicaid statute such that the latter should be interpreted to protect plaintiffs while the MSP endangers their recoveries. This Note argues that the government's right to recover Medicare payments should be limited to the portion of settlement funds representing compensation for past medical expenses.

A. *The Statutes Governing Medicare and Medicaid Repayment Obligations Are Best Understood as Similarly Limiting the Government's Recovery Right*

Medicare and Medicaid share the same enabling legislation and basic repayment obligations. The Medical Care Recovery Act of 1962⁷⁰ has commonly been recognized as the enabling legislation.⁷¹ The statute recognizes the government's recovery rights but also suggests that right is not without limits, authorizing only "the *reasonable* value of the care and treatment so furnished [or] paid for."⁷²

The language of the federal Medicare statute has been interpreted to limit the government's recovery to the plaintiff's recovery for past medical expenses, and the Medicare statute should be as well. The Medicaid Act provides that as a condition

⁶⁸ See Timothy V. Hoffman & George L. Acosta, *Beware of the "Super Lien": Medicare Payments' Effect on Personal Injury Cases*, 81 ILL. B.J. 81, 81 (1993) (noting that the Medicare lien is unique because "federal regulations grant Medicare subrogation and lien rights superior to any other lien or interest on any settlement or judgment proceeds. These rights apply even though no . . . notice was sent out and even when the liability insurer and parties' attorneys are not aware that payments had been made by Medicare."); see also Thomas J. Nyzio, *Medicare Recovery in Liability Cases*, 7 S.C. LAW. 20, 20 n.1 (1996).

⁶⁹ See Sally Hart, *Recovery Powers Under Medicare's Secondary Payer Program*, J. ASS'N TRIAL LAW. AM., Sept. 1997, at 54. Hart also suggests that an overzealous interpretation of the government's recovery rights under Medicare could lead to a breach of attorney professional obligations to their client. She contends that if attorneys act as if the Medicare lien is a super lien, priority payments to the government may create situations where payment was not warranted at all. *Id.* at 58.

⁷⁰ 42 U.S.C.A. § 1395y(b)(2)(B) (West 2010).

⁷¹ See, e.g., Hayes, *supra* note 44.

⁷² 42 U.S.C. § 2651(a) (2006) (emphasis added).

of eligibility, a Medicaid recipient must “assign the State any rights . . . to payment for medical care from any third party.”⁷³ The Supreme Court determined that this portion of the federal third-party liability provision suggested that ADHS could not “lay claim to more than the portion of Ahlborn’s settlement that represents medical expenses.”⁷⁴ Similarly, the MSP enables the government to recoup funds from primary plans having “responsibility to make payment with respect to *such item or service*.”⁷⁵ The Ninth Circuit has noted that “[n]othing in [the statute’s] language . . . compels the conclusion that Congress intended to limit the amount of recovery for a conditionally paid ‘item or service’ to a proportionate share of a discounted settlement.”⁷⁶ The Ninth Circuit has also conceded that it was “clear from the statute that the references to [the] ‘item or service’ [were] intended to define the payments for which Medicare has a right to reimbursement.”⁷⁷ Thus, it is reasonable to conclude that the government’s reimbursement rights under Medicare were intended to be limited to payments made by the defendant for the plaintiff’s past medical services, not unrelated compensation, such as pain and suffering.

There are significant differences between the Medicare and federal Medicaid statutes, but disparities in the administration of the programs or reimbursement procedures do not translate into statutorily prescribed differences in amounts recoverable. For example, the Medicaid statute is based upon an assignment of rights intended to further recovery. States are obligated to enact laws under which the state acquires the Medicaid beneficiary’s right to seek reimbursement from third parties found liable to pay for medical bills and services.⁷⁸ The state then reimburses the federal government to the extent it helped finance the medical assistance.⁷⁹ In contrast, the MSP establishes that Medicare will make conditional payments, subject to recovery when a third-party payer is deemed responsible for items and

⁷³ *Id.* § 1396k(a)(1)(A) (emphasis added).

⁷⁴ See *Ark. Dep’t of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 280 (2006).

⁷⁵ 42 U.S.C.A. § 1395y(b)(2)(B)(ii) (emphasis added).

⁷⁶ *Zinman v. Shalala*, 67 F.3d 841, 844 (9th Cir. 1995).

⁷⁷ *Id.*

⁷⁸ See 42 U.S.C.A. § 1396a(25)(H) (West 2010); 42 U.S.C. 1396k(a)(1)(A).

⁷⁹ See 42 U.S.C. § 1396k(b).

services provided by Medicare.⁸⁰ Medicare's right of recovery is more direct than Medicaid's, but nothing in the language suggests that the government is entitled to recover any more under Medicaid than under Medicare.

Statutory differences in the way the government may recoup funds from each program are better explained by differences in the way the programs are administered. Medicaid programs are created and run by each individual state, whereas Medicare is a federal program.⁸¹ Recovery of federal funds under each program requires different procedures to meet those goals, with Medicare requiring stronger recovery rights since there is no state oversight. For example, the MSP has a double damages provision, whereas the federal Medicaid statutes do not. The MSP grants "CMS the right to collect double damages plus interest for any attempt at cost shifting from a primary payer onto Medicare."⁸² While this may be seen as evidence of the government's "super" recovery powers, the provision is better understood as a reflection of the government's desire to reduce Medicare expenditures. First, it acts as a deterrent against cost shifting, thereby ensuring compliance with reimbursement requirements. Second, it provides an additional influx of money from which the government can reimburse itself without compromising funds needed to compensate tort victims.

B. Protecting Medicare Payment Recovery While Maintaining the Tort System

The government's interest in recoupment of Medicare funds must be balanced with the tort system's goal of compensating victims. Allowing the government unlimited recovery of Medicare expenses from tort settlements threatens the efficiency of the tort system because diminished recovery will discourage (1) plaintiffs from bringing suit, (2) attorneys from taking claims, and (3) defendants from settling. Limiting recovery to those funds representing compensation for past medical expenses will enable the government to decrease expenditures while also ensuring that tort victims are compensated. This will also decrease the tort victims' dependence on federal assistance. The

⁸⁰ See 42 U.S.C.A. § 1395y(b)(2)(B).

⁸¹ See *supra* Part II.A.

⁸² Schmidt, *supra* note 28, at 474 (citing 42 U.S.C.A. § 1395y(b)(2)(A)).

government need not worry that parties to the suit will negotiate away its interest because the government is well equipped to recover on its own, and statutory provisions already in place provide additional incentives for parties to protect the government's interests.

1. Granting the Government Full Recovery Rights Threatens the Tort System's Ability To Compensate

The tort system can effectively compensate victims only if it is structured so that plaintiffs have adequate incentives to seek redress for their wrongs. The tort system seeks to make aggrieved parties whole, but this can only be accomplished if the injured party seeks redress, has the resources to pursue the case, and will actually be compensated for his or her harm.⁸³ Through the tort system, the burden of making the victim whole is placed upon the person who is most justly burdened with the cost.⁸⁴ Society has a strong interest in ensuring that claims come forward and victims are adequately compensated because those costs might otherwise continue to be born by public financing.⁸⁵ Interpreting the MSP to grant the government full recovery rights would threaten the tort system's ability to make plaintiffs whole because high costs deter plaintiffs from seeking redress, attorneys from accepting cases, and defendants from settling.

The harsh effects of a broad recovery right have been felt by plaintiffs and acknowledged by judges. Because plaintiffs are the last entity to receive funds from a settlement,⁸⁶ they can easily be left with little or no compensation.⁸⁷ Judge Weinstein noted that

⁸³ In general, plaintiffs will likely bring a claim if they expect that the benefits from a favorable judgment or settlement will outweigh the cost of achieving that outcome. See Swedloff, *supra* note 2, at 599. See generally Robert D. Cooter & Daniel L. Rubinfeld, *Economic Analysis of Legal Disputes and Their Resolution*, 27 J. ECON. LITERATURE 1067 (1989) (discussing the economic gains and losses involved in legal dispute resolution).

⁸⁴ See Benjamin C. Zipurksy, *Civil Recourse, Not Corrective Justice*, 91 GEO. L.J. 695, 695 (2003) ("American tort law recognizes the corrective justice ideal by providing a mechanism through which defendants who have wrongfully injured plaintiffs are required to compensate those plaintiffs for their injuries, and thereby make them whole insofar as this is practically possible.").

⁸⁵ See Russell, *supra* note 48, at 1064 (noting that tort law protects the public from the responsibility of compensation).

⁸⁶ See 42 U.S.C. § 1396k(b) (2006) (stating that the state and federal government collect first, with the remainder paid to the Medicare beneficiary and his or her attorney).

⁸⁷ See, e.g., *Zinman v. Shalala*, 67 F.3d 841, 844–45 (9th Cir. 1995).

this harsh, but real, result of the full reimbursement approach "gives many beneficiaries little incentive to pursue valid claims or, if they do, to accept otherwise reasonable settlement offers, thereby tending to push them into uncertain litigation that burdens the courts and may result in little or no recovery for either the beneficiaries or for Medicare or Medicaid."⁸⁸ A full reimbursement rule would ultimately defeat the core values of the Medicare and Medicaid programs by "depriv[ing] poor and injured individuals of needed compensation for their pain and suffering, lost wages, and other non-medical damages."⁸⁹

Additionally, allowing the government full recovery from settlements makes Medicare beneficiaries undesirable clients for medical malpractice attorneys because it reduces their net recovery. Plaintiffs' attorneys will only agree to representation when they believe it is profitable to do so. A medical malpractice case involving a Medicare lien, subject to full recovery, would reduce the value of the case for a number of reasons. First, there are higher costs associated with the representation because Medicare beneficiary cases are more likely to go to trial than to settle.⁹⁰ Additionally, after higher costs to obtain diminished rewards, the attorney's fee may still be reduced or completely eliminated. The MSP provides that the Secretary may recover conditional payments made by Medicare from "any entity that . . . receive[s] payment from a primary plan."⁹¹ Thus, attorneys who accept contingency fees from a tortfeasor's payout are subject to the Secretary's right of recovery. These rising costs and reduced expected benefits would discourage plaintiffs' attorneys from bringing a suit with the ultimate result that tort victims will be harder pressed to find adequate legal representation, and thus, less likely to seek compensation for their injuries.

Finally, defendants are discouraged from settling lawsuits with Medicare beneficiaries because of increased costs as a result of repayment obligations.⁹² Settlements should be encouraged because they compensate victims in an efficient manner.⁹³ After

⁸⁸ *In re Zyprexa Prods. Liab. Litig.*, 451 F. Supp. 2d 458, 470 (E.D.N.Y. 2006).

⁸⁹ *Id.*

⁹⁰ See *infra* notes 92–98 and accompanying text.

⁹¹ 42 U.S.C.A. § 1395y(b)(2)(B)(iii) (West 2010).

⁹² See Swedloff, *supra* note 2, at 588 ("It should be intuitively obvious that Medicare beneficiaries will have difficulty settling tort claims under the MSP.").

⁹³ See Schmidt, *supra* note 28, at 484.

the 2003 amendments to the MSP, however, settlements are less desirable to defendants because “[a]ny time a Medicare beneficiary compromises or releases his claims in exchange for a settlement with an alleged tortfeasor, a court must hold that the alleged tortfeasor has a primary plan under the MSP.”⁹⁴ Defendants will, therefore, be responsible to the government for Medicare’s payments to the beneficiary because the United States may bring a reimbursement claim against primary plans.⁹⁵ If settlements do not explicitly include compensation for past medical expenses, at a minimum, the defendant may have to pay twice: once to the Medicare beneficiary for the settlement and once to the government for its Medicare reimbursement claim.⁹⁶ Plaintiffs are unlikely to agree to a settlement that includes Medicare’s expenses because then they are responsible for reimbursement, which diminishes their recovery. Defendants may face even greater financial burdens if settlements proceed but fail to adequately protect Medicare’s recovery rights, thereby forcing the defendant to pay “double damages” to Medicare on top of settlement costs.⁹⁷ Since a settlement creates additional, automatic liability to Medicare, “defendants will perceive this as an additional cost of settlement and plaintiffs will perceive the liability as reducing the amount that they can expect to receive from a settlement.”⁹⁸ From a defendant’s perspective, increased settlement costs make litigation more enticing because a victory would avoid plaintiff compensation and Medicare reimbursement. From a plaintiff’s standpoint, a successful trial would provide a larger pool of money from which they would have to reimburse Medicare.

2. Protection of Governmental Interests

Before *Ahlborn*, the government argued “that if States were limited to recovering payments from third parties for medical care and services, then recipients could prevent state recovery by intentionally manipulating the amounts paid

⁹⁴ Swedloff, *supra* note 2, at 585.

⁹⁵ See 42 U.S.C.A. § 1395y(b)(2)(B)(ii)–(iii).

⁹⁶ See Swedloff, *supra* note 2, at 585.

⁹⁷ See *id.* at 585–86.

⁹⁸ *Id.* at 591.

for various claims.”⁹⁹ Concern that a limited interpretation of the government’s reimbursement rights under the MSP would lead the parties to the lawsuit to negotiate away the government’s interest, significantly diminishing recoupment ability, lacks merit. First, strong incentives exist for attorneys, plaintiffs, and defendants to respect the government’s right of reimbursement. Second, the government can protect its own interest by joining in or initiating legal proceedings to assert reimbursement rights. The picture painted went something like this: Medicaid or Medicare recipients would collude with the defendant to reduce the amount of the settlement representing compensation for past medical expenses paid by the government, or exclude it entirely, while increasing funds designated for pain and suffering.¹⁰⁰ Attempts by plaintiffs to seek compensation for only nonmedical expenses, specifically excluding monies recoverable by the government, have been of particular concern.¹⁰¹

It is in the attorney’s best interest to cooperate with Medicare’s recoupment efforts because his or her portion of the settlement may be reduced if Medicare’s interest is not satisfied. Medicare may reduce the award of any person who attempts to shift the primary cost of care to Medicare that “knew or should have known about [Medicare’s] payments but failed to protect Medicare’s recovery rights.”¹⁰² Prudent attorneys are likely to understand Medicare repayment obligations, and therefore, be motivated by a possible reduction of their attorney fees. If financial consequence is not enough, the looming possibility of legal action against the attorney, detracting from his or her valuable time and reputation, provides additional incentive. Federal regulations state that CMS may sue “any entity,

⁹⁹ *Ahlborn v. Ark. Dep’t of Human Servs.*, 397 F.3d 620, 627 (8th Cir. 2005), *aff’d*, 547 U.S. 268 (2006).

¹⁰⁰ *See id.*

¹⁰¹ *See id.* In North Carolina, for example, plaintiffs attempted to apportion damages to avoid Medicaid liens. *See* Allen N. Trask, III, Comment, *Orders from on High: The Current Struggle over Medicaid Third Party Recovery Between North Carolina and the Supreme Court of the United States*, 30 CAMPBELL L. REV. 471, 487 (2008). Some commentators, however, argue that this is a desirable situation. J. Michael Hayes contends that the government should exercise its independent right to seek recovery, thus representing their own interests, and claimants should restrict their personal injury claims to pain and suffering. *See* Hayes, *supra* note 44, at 30.

¹⁰² Nyzio, *supra* note 68, at 23.

including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.”¹⁰³ Through these administrative regulations, the government has put attorneys on notice that they will pursue recovery of Medicare reimbursements from both plaintiffs and attorneys—even after such settlement funds have been dispersed.¹⁰⁴

The legal community has stressed the importance of harmonizing the government’s recovery goal with the tort system’s interest in adequately compensating injured plaintiffs. For example, in seeking to reconcile North Carolina practices with the *Ahlborn* decision, one commentator argued that North Carolina should amend its statutes to mandate that the North Carolina Division of Medical Assistance participate in settlement negotiations.¹⁰⁵ That type of an amendment would protect the government’s interest by precluding attempts to keep the government in the dark while damages were apportioned in a way that avoids the government’s interests.¹⁰⁶ Additionally, a recent article in the New York State Bar Journal suggests that attorneys should provide Medicare with a copy of the complaint at the start of the action. This would put Medicare on written notice and advise Medicare to retain its own counsel so it may join in the suit or start its own suit to pursue medical expenses.¹⁰⁷ In *Ahlborn*, the Supreme Court rejected the government’s concerns, instead suggesting that “the risk that parties to a tort suit will allocate away the State’s interest can be avoided either by obtaining the State’s advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.”¹⁰⁸

Finally, the government is well equipped to protect its own interests by bringing its own actions or joining in the Medicare beneficiary’s suit to participate in settlement negotiations. The government is authorized to recover Medicare expenses “in any case in which [it] is authorized or required by law to . . . pay for hospital, medical, surgical, or dental care and treatment . . . to a

¹⁰³ 42 C.F.R. § 411.24(g) (2010).

¹⁰⁴ See Glenn E. Bradford & Melinda M. Ward, *The Medicare “Super Lien” Revisited*, 56 J. MO. B. 44, 45 (2000).

¹⁰⁵ See Trask, *supra* note 101.

¹⁰⁶ See *id.*

¹⁰⁷ See Hayes, *supra* note 44, at 31.

¹⁰⁸ Ark. Dep’t of Health & Human Servs. v. Ahlborn, 547 U.S. 268, 288 (2006).

person who is injured . . . under circumstances creating a tort liability upon some third person . . . to pay damages therefor.”¹⁰⁹ First, the government has a right, independent of the injured person, to recover the reasonable value of the care or treatment that was furnished from third persons that caused the injury.¹¹⁰ Additionally, the government is subrogated to any right or claim of the injured person,¹¹¹ allowing the head of the department or agency of the United States that furnished the care or treatment provided for by the government to require the injured parties to assign their rights to the government.¹¹² To enforce these rights, it may “intervene or join in any action or proceeding brought by the injured or diseased person . . . against the third person who is liable for the injury . . . or other entity responsible for the payment or reimbursement of medical expenses.”¹¹³ Further protection is provided by the fact that, if no such action is brought within six months after the care or treatment is paid for by the United States, the government may “institute and prosecute legal proceedings against the third person who is liable for the injury . . . or other entity responsible for the payment or reimbursement of medical expenses.”¹¹⁴ Thus, the government need not fear that a limited recovery rule would harm its recoupment efforts.

IV. APPLICATION

Applying the Medicaid rule established in *Ahlborn* to Medicare requires apportioning settlement proceeds through a mathematical formula or submitting the matter to a court for determination. The *Ahlborn* formula, which reduces the government's recovery by the fraction that the plaintiff's total claim was reduced to through settlement, is an efficient and fair apportionment method when the portion of the settlement meant to compensate for past medical expenses is easily discernable. In

¹⁰⁹ 42 U.S.C. § 2651(a) (2006).

¹¹⁰ *Id.* (“[T]he United States shall have a right to recover (independent of the rights of the injured or diseased person) from said third person . . . the reasonable value of the care and treatment so furnished [or] paid for . . .”).

¹¹¹ *Id.* (“[T]he United States . . . shall . . . be subrogated to any right or claim that the injured or diseased person . . . has against such third person to the extent of the reasonable value of the care and treatment so furnished . . .”).

¹¹² *Id.*

¹¹³ *Id.* § 2651(d).

¹¹⁴ *Id.*

other cases, judicial oversight can determine the relevant values, ensuring a fair result for both plaintiffs and the government. While judicial intervention requires significant resources, the fair reconciliation of the government's financial interests with the plaintiff's right to compensation is worth the trouble.

A. *Ahlborn's Fractional Formula for Stipulated Past Medical Expenses*

The *Ahlborn* decision created a formula that would allow courts to expeditiously determine the allocation of settlement funds. The formula dictates that the court "should determine the ratio between the settlement amount and the actual value of the case, and then apply that same ratio to medical expenses."¹¹⁵

In *Ahlborn*, the parties settled for \$500,000.¹¹⁶ Later, they stipulated that "the settlement amounted to approximately one-sixth of [the reasonable value of Ahlborn's claim]; and that, if Ahlborn's construction of federal law was correct, ADHS would be entitled to only the portion of the settlement (\$35,581.47) that constituted reimbursement for medical payments made."¹¹⁷ The total value of Ahlborn's claim was estimated at \$3,040,708.12.¹¹⁸ Thus, ADHS would be entitled to about one-sixth of the \$215,645.30 lien—representing past medical expenses paid out by Medicare—leaving them free to recoup \$35,581.47 from the settlement proceeds.¹¹⁹ Where the parties to a lawsuit involving Medicare reimbursement issues have stipulated the portion of the settlement proceeds intended to compensate for past medical expenses, courts should apply the fractional formula

Various courts have accepted the formula approach as a rational apportionment method.¹²⁰ The Supreme Court gave no indication of dissatisfaction with the formula, despite the fact

¹¹⁵ *Lugo v. Beth Israel Med. Ctr.*, 13 Misc. 3d 681, 687, 819 N.Y.S.2d 892, 896–97 (Sup. Ct. N.Y. County 2006).

¹¹⁶ *Id.*

¹¹⁷ *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 274 (2006).

¹¹⁸ *See id.*

¹¹⁹ *See id.*

¹²⁰ *See, e.g., Lugo*, 13 Misc. 3d at 687, 819 N.Y.S.2d at 897 (concluding that the formula used in *Ahlborn* was rational); *see also* Robert W. Hambrecht, 'Lugo'/Allocation Hearing Ordered in Action To Recoup Medicaid, Medicare Liens, N.Y. L.J., Sept. 10, 2007, at 19 (stating that, at first glance, an application of the *Ahlborn* formula, which would reduce the Medicaid reimbursement to 3.4% of the total settlement in the instant case, seemed to allow for a reasonable recoupment).

that it was stipulated to by the parties. On the contrary, the court in *Lugo* surmised that the Supreme Court seems to fully sanction that method of apportionment "by equating the stipulation to a judicial determination allocating the award."¹²¹ The *Lugo* Court stated that "the 'effect of the stipulation is the same as if a trial judge had found that Ahlborn's [ability to recover on the award of] damages' was limited in proportion to the percent of comparative negligence determined by the court."¹²²

B. Judicial Allocation of Settlement Proceeds for Unstipulated Past Medical Expenses

If parties to a lawsuit have not stipulated to apportionment of a settlement, the court should still apply the fractional formula by determining the allocation of settlement proceeds. As an initial matter, the court should determine whether any medical expenses were included in the settlement.¹²³ Such a step would provide the most protection to plaintiffs by ensuring that Medicare has a right of recovery given the specific facts of the case.¹²⁴ This type of direct, initial judicial oversight would also alleviate concerns that "[a]ppportionment of Medicare's recovery in tort cases . . . would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages."¹²⁵

The court should then determine what portion of the settlement represents compensation for past medical expenses. The government should submit to judicial review if it is unable or unwilling to resolve its claims with Medicare beneficiaries. Although rare, the government has submitted to third-party review in this area before. For example, when a neutral arbitrator specifically designates certain funds for items not

¹²¹ *Lugo*, 13 Misc. 3d at 688, 819 N.Y.S.2d at 897.

¹²² *Id.* (quoting *Ahlborn*, 547 U.S. at 281 n.10).

¹²³ See *Harris v. City of N.Y.*, 16 Misc. 3d 674, 679–80, 837 N.Y.S.2d 486, 490 (Sup. Ct. N.Y. County 2007) ("[I]t is for the court to determine the extent to which a personal injury settlement addresses the claim for past medical expenses . . ."); Trask, *supra* note 101, at 486 ("The *Ahlborn* decision first requires that either the parties, or the courts by decree, apportion the damages by category.").

¹²⁴ See Thomas A. Moore & Matthew Gaier, *Medicaid Liens Revisited*, N.Y. L.J., June 3, 2008, at 3 (arguing that there is no reason that any proceeds of a settlement should go to the Medicaid agency when the plaintiff settles for less than the full amount of the case).

¹²⁵ *Zinman v. Shalala*, 67 F.3d 841, 846 (9th Cir. 1995).

related to medical expenses, such as pain and suffering, “Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services”¹²⁶ Perhaps the government accepts reduction of its claim because such allocations are the result of a court order on the merits, alleviating fears that attorneys are colluding to disadvantage the government out of its reimbursement interest.

Although damages in tort suits are less susceptible to precise determination—and thus, would “require a factfinding process to determine the actual damages”¹²⁷—the Supreme Court has seemed to sanction judicial oversight of the process. In *Ahlborn*, the Supreme Court concluded that allocation may sometimes require “submitting the matter to a court for decision.”¹²⁸ The Court reasoned that “just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others.”¹²⁹

Judicial intervention is costly in terms of time and money, but it is worthwhile to ensure a harmonious functioning of the tort system and the Medicare program. History has shown that cooperation between the injured party and Medicare is difficult due to their competing interests. The Association of Trial Lawyers of America has explained that “Medicare . . . [is] notorious for refusing to provide information regarding claimed lien amounts until after a tort claim has been settled.”¹³⁰ Plaintiffs and defendants have attempted to exclude the government from their settlements. A middle ground is required, however, so that each side can maximize its recovery while maintaining the effectiveness of the tort and Medicare systems. Plaintiffs who are Medicare recipients benefit from a well-funded Medicare program because they may need services in the future.

¹²⁶ Matthew L. Garretson, *What Does the Ahlborn Decision Really Mean? Medicaid Reimbursement in Personal Injury Cases After Arkansas Dep’t of Health & Human Services v. Ahlborn*, 36 TORTS, INS. & COMPENSATION L. SEC. J. 22, 24 (2007); see also *Zinman v. Shalala*, 835 F. Supp. 1163, 1167 (N.D. Cal. 1993), *aff’d*, 67 F.3d 841.

¹²⁷ *Zinman*, 67 F.3d at 846.

¹²⁸ *Ark. Dep’t of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 271 (2006).

¹²⁹ *Id.* at 288.

¹³⁰ Brief of the Ass’n of Trial Lawyers of America as Amicus Curiae in Support of Respondents at 11, *Ahlborn*, 547 U.S. 268 (No. 04-1506).

The Medicare program benefits from the recovery of adequate funds by Medicare-recipient plaintiffs in that the plaintiffs will become less dependent on public funding.¹³¹

CONCLUSION

The fact that Congress intended Medicare to be the payer of last resort does not mean that Congress intended for the government to be able to recoup its losses from funds intended to compensate plaintiffs for nonmedical costs, such as pain and suffering. The Supreme Court's determination that the government's right to recoup Medicaid payments is limited should guide judicial interpretation of government reimbursement rights for Medicare because the programs have the same basic repayment obligations—limiting recovery to payments for medical expenses. A limited recovery rule may be more difficult to implement than a blanket rule allowing full recovery, but the aftermath of *Ahlborn* has shown that tort victims need not suffer for the government to receive its just compensation. In the end, the interests of the government and the tort system can be reconciled.

¹³¹ See Russell, *supra* note 48, at 1064.